EXHIBIT GG

New York State Department of Health

Certificate of Qualification

CQ Code: ROTHEL

Erio Roth, M.D.

1401 Burr Oak Road, Apt. 308B
Hinsdale IL 60521

has qualified to act as a Laboratory Director in the following categories
in accordance with Article 5, Title V, Section 573 of the Public Health Law.

Bacteriology	*Diagnostic Immunology*	*Mycology*
Clinical Chemistry	*Endocrinology*	*Parasitology*
Clinical Toxicology	*Histopathology*	*Ther. Sub. Mon./Quant. Tox.*
Cytopathology	*General*	

STATE OF NEW YORK
DEPARTMENT OF HEALTH

Amended

Effective Date: December 17, 2003
Expiration Date: June 14, 2004

Subject to Revocation
Certificate Not Transferable

POST CONSPICUOUSLY

Serial: COP21403

NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, P.O. BOX 509
ALBANY, NEW YORK 12201-0509

FOR OFFICE USE ONLY
Recd. ______
Fee No. ______
PFI: ____ Code No. ______
CLIA No. ______

APPLICATION FOR INITIAL PERMIT

Laboratory Contact Person to Arrange On-Site Inspection: Douglas Dolbke

Telephone Number: 773-693-0400 Projected Opening Date: ______

1. GENERAL LABORATORY INFORMATION

NAME OF LABORATORY: (Please limit number of characters to 70) BioSafe Laboratories, Inc.	FEDERAL EMPLOYER ID NO. 364213449
ADDRESS (NUMBER AND STREET) 6600 W. Catalpa Ave.	COUNTY Cook
CITY, TOWN OR VILLAGE Chicago | STATE IL | ZIP CODE 60656	THIS LABORATORY [ ] IS [✓] IS NOT A SMALL BUSINESS
LABORATORY TELEPHONE NUMBER (773) 693-0400 FAX NUMBER (773) 693-0410 | Email Address dougdolbke@biosafemt.com	DAYS AND HOURS WHEN TESTS ARE PERFORMED: M 0830 to 1700; Tu 0830 to 1700; W 0830 to 1700; Th 0830 to 1700; F 0830 to 1700; Sa — to —; Su — to —

2. OWNERSHIP INFORMATION

A. Type of ownership: 1 [ ] Individual 2 [ ] Partnership 3 [✓] Corporation or [ ] Not-For-Profit Corporation 4 [ ] Government

B. Name of owner(s) or corporation: BioSafe Medical Technologies, Inc.

C. Owner/corporation address of principal office: 100 Knightsbridge Pkwy, Suite 320 Lincolnshire, IL 60069

D. List all individuals having direct or indirect ownership or a controlling interest on the enclosed Ownership and Controlling Interest Disclosure Statement form (DOH-3486).

3. FACILITY TYPE

For any facility type indicated with an asterisk, provide a copy of your NYS License or Operating Certificate, if your facility is located in New York State.

[ ] Ambulatory Surgery Center*
[ ] Community Clinic*
[ ] Comprehensive Outpatient Rehabilitation Facility*
[ ] Ancillary Testing Site in Health Care Facility*
[ ] End State Renal Disease Dialysis Facility*
[ ] Health Maintenance Organization*
[ ] Home Health Agency*
[ ] Hospice*
[ ] Hospital*
[✓] Independent
[ ] Industrial
[ ] Insurance
[ ] Intermediate Care Facility for the Mentally Retarded*
[ ] Mobile Unit
[ ] Pharmacy
[ ] School/Student Health Service
[ ] Skilled Nursing Facility or Nursing Facility*
[ ] Tissue Banks/Repositories*
[ ] Other (Please Describe)

5

4. OTHER APPROVALS

CLIA NO. 33D2092821 [✓] Approved [ ] Pending [ ] Requested (New York State Laboratories Only)

To be completed by laboratories located in New York State ONLY.
MEDICAID NO. _____ [ ] Approved [ ] Pending [ ] Not Requested

5. OTHER INFORMATION	YES	NO
Is the laboratory operating Patient Service Centers (Collecting Stations) or Limited Testing Sites?		✓
If yes, you must complete a separate application for each. Applications can be obtained by contacting our office (see instructions).		
Is the laboratory operating a mobile courier service?		✓
Is laboratory operated under a management contract?		✓
If yes, give name of management company and attach a copy of the contract.		

6. LABORATORY FACILITIES

A. Description of the laboratory facility Please provide a drawing of laboratory quarters or a blueprint, if available, and answer the following questions: 1. Is all laboratory space contiguous? If no, please indicate other location(s).	✓	
2. What is the total approximate square footage of the laboratory work space? Square Feet 3600		
3. Is the laboratory located within space occupied by any other health service provider? If yes, please explain.		✓

B. Laboratory equipment

List and briefly describe the equipment, which is or will be located in the laboratory (e.g., microscopes, incubators, water baths, sterilizers, centrifuges, photometers). Use additional sheets if necessary.

Beckman Coulter CX 7 Chemistry Analyzer
DPC Vmax Kinetic Microplate Reader
DPC Micromix 5 microplate mixer
DPC Microwash 5 microplate washer
DPC Microlite 3, microplate pipetting station
Bio Tech Inst. EL404 Microplate Washer
Hybritech Variable Plate Rotator
Labline Inst. Titer Plate Shaker
Beckman TJ-6 Centrifuge
Precision Incubator
Denver Inst. Analytical Balance
Ohaus Harvard Trip Balance

PFI:

7. Technical Personnel

List on the enclosed "Personnel Consolidation Sheet (DOH-709) the technical personnel working in the laboratory. You may attach employee personnel rosters or listings provided they are set up in the same format.

8. Laboratory Directorship

A. Laboratory Director:

Title: 1[✓] Dr. 2[ ] Mr. 3[ ] Ms. 4[ ] Miss 5[ ] Mrs.	CO Code:	Or applied for CO? Yes [✓] No [ ]	Social Security Number: 325-48-8000
First Name: Milan			Middle Initial:
Last Name: Babich			
Home Address - Number and Street: 15004 Pleasant Valley Road			
City, Town or Village: Woodstock		State: IL	Zip Code: 60098

Hours:
M ____ to ____ W 1000 to 1400 F ____ to ____ Su ____ to ____
Tu ____ to ____ Th ____ to ____ Sa ____ to ____

Director Status: 1[ ] Full-time 2[✓] Part-time Degree(s) Held: 1[✓] M.D. 2[ ] D. O. 3[ ] D.D.S. 7[ ] So.D. 4[ ] D.V.M. 6[ ] Ph.D. 8[ ] D.SC.

B. Other Employment of Director

List all other employers of the director, including private practice, service to other laboratories, and non-health related facilities. Provide days of the week and hours per day served, and give title or brief description of duties.

Name and Address of Institution/Employer	Hours: From - To	Title/Duties
Sherman Hospital 934 Center St. Elgin, IL 60120	M 8-5 Tu 8-5 W ____ Th ____ F 8-5 Sa ____ Su ____	Psychologist, ME, CP
	M ____ Tu ____ W ____ Th ____ F ____ Sa ____ Su ____	
	M ____ Tu ____ W ____ Th ____ F ____ Sa ____ Su ____	

PFI: ________

C. Assistant Directors:
Excluding the director, list below those personnel serving the laboratory as assistant directors who hold Certificate(s) of Qualification and who assume personal responsibility for tests performed. All assistant director(s) must read the certification and sign and date this application on page 6. Attach additional sheets if necessary. Personal responsibility for categories must be indicated on page 8.

Assistant Director

Title: 1[ ] Dr. 2[ ] Mr. 3[ ] Ms. 4[ ] Miss 5[ ] Mrs.	CQ Code: Or applied? Yes [ ] No [ ]	Social Security Number:
First Name:		Middle Initial:
Last Name:		
Home Address - Number and Street:		
City, Town or Village:	State:	Zip Code:
Hours: M ____ to ____ Tu ____ to ____ W ____ to ____ Th ____ to ____ F ____ to ____ Sa ____ to ____ Su ____ to ____		
Assistant Director Status: 1[ ] Full-time 2 [ ] Part-time	Degree(s) Held: 1[ ] M.D. 2[ ] D.O. 3[ ] D.D.S. 4[ ] D.V.M. 5[ ] Ph.D. 6[ ] D.SC. 7[ ] Sc.D.	

Assistant Director

Title: 1[ ] Dr. 2[ ] Mr. 3[ ] Ms. 4[ ] Miss 5[ ] Mrs.	CQ Code: Or applied? Yes [ ] No [ ]	Social Security Number:
First Name:		Middle Initial:
Last Name:		
Home Address - Number and Street:		
City, Town or Village:	State:	Zip Code:
Hours: M ____ to ____ Tu ____ to ____ W ____ to ____ Th ____ to ____ F ____ to ____ Sa ____ to ____ Su ____ to ____		
Assistant Director Status: 1[ ] Full-time 2 [ ] Part-time	Degree(s) Held: 1[ ] M.D. 2[ ] D.O. 3[ ] D.D.S. 4[ ] D.V.M. 5[ ] Ph.D. 6[ ] D.SC. 7[ ] Sc.D.	

Assistant Director

Title: 1[ ] Dr. 2[ ] Mr. 3[ ] Ms. 4[ ] Miss 5[ ] Mrs.	CQ Code: Or applied? Yes [ ] No [ ]	Social Security Number:
First Name:		Middle Initial:
Last Name:		
Home Address - Number and Street:		
City, Town or Village:	State:	Zip Code:
Hours: M ____ to ____ Tu ____ to ____ W ____ to ____ Th ____ to ____ F ____ to ____ Sa ____ to ____ Su ____ to ____		
Assistant Director Status: 1[ ] Full-time 2 [ ] Part-time	Degree(s) Held: 1[ ] M.D. 2[ ] D.O. 3[ ] D.D.S. 4[ ] D.V.M. 5[ ] Ph.D. 6[ ] D.SC. 7[ ] Sc.D.	

B. CATEGORIES OR SUBCATEGORIES FOR WHICH YOU SEEK A LABORATORY PERMIT

Indicate CQ Code for all individuals (director/assistant director) responsible for each category requested. Attach additional sheets if necessary. Refer to descriptions of categories enclosed.

	CQ CODE OF RESPONSIBLE DIR/ASST.DIR
* **Bacteriology**	
[ ] General	
[ ] Gram Stains	
[ ] Limited Gonorrhea and Chlamydia	
[ ] Limited Throat Culture	
[ ] Limited Urine Screening	
[ ] Limited Urine Culture	
[ ] Antigen Detection	
[ ] Antigen Detection-Group A *Streptococcus*	
[ ] Blood pH and Gases	
* **Blood Services**	
[ ] Collection	
[ ] Collection-Autogenais Only	
[ ] Transfusion	
[ ] Transfusion Storage Only	
[ ] Plasma Fractionation	
* **Cellular Immunology**	
[ ] Limited I	
[ ] Limited IIA	
[ ] Limited IIB	
[ ] Limited III	
[ ] Limited IVA	
[ ] Limited IVB	
[✓] **Clinical Chemistry**	
[ ] Limited	
* **Cytogenetics**	
[ ] Prenatal Cytogenetics	
[ ] Limited Cytogenetics	
[ ] Cancer Cytogenetics	
[ ] * **Cytopathology**	
* **Diagnostic Immunology**	
[✓] Diagnostic Services Serology	
[ ] Donor Services Serology	
[ ] **Endocrinology**	
[ ] **Forensic/Identity Testing**	
* **Genetic Testing**	
[ ] DNA Based	
[ ] Biochemistry	
* **Hematology**	
[ ] Cellular Hematology	
[ ] Coagulation	
[ ] Comprehensive	
[ ] Other Tests	
[ ] Cytohematology Limited	
[ ] Cytohematology Diagnostic	
* **Histocompatibility**	
[ ] Limited	
[ ] General	

	CQ CODE OF RESPONSIBLE DIR/ASST.DIR
Histopathology	
[ ] Oral Pathology	
[ ] Dermatopathology	
[ ] General	
* **Human Immunodeficiency Virus**	
[ ] Limited A	
[ ] Comprehensive A	
[ ] Limited B	
[ ] Comprehensive B	
[ ] * **Immunohematology**	
Mycobacteriology	
[ ] Smears Only	
[ ] Restricted	
[ ] Limited	
[ ] Limited-S	
[ ] General	
[ ] General-S	
Mycology	
[ ] Limited - Yeast Only	
[ ] General	
* **Oncofetal Antigens**	
[ ] Fetal Defect Markers	
[ ] Fetal Defect Markers-Amniotic Fluid Only	
[ ] Fetal Defect Markers-Sera and Amniotic Fluid	
* **Oncology**	
[✓] Sera and Soluble Tumor Markers	
[ ] Molecular Detection	
[ ] * **Parasitology**	
* **Paternity/Identity Testing**	
[ ] General	
[ ] Limited HLA Testing	
[ ] Limited Blood Genetic Marker Testing	
[ ] Limited DNA Testing	
[ ] **Ther. Sub. Mon./Quant. Toxicology**	
* **Toxicology**	
[ ] Forensic Toxicology	
[ ] Drug Anal. Qualitative	
[ ] Emergency Toxicology	
[ ] Qualitative Toxicology-Rehabilitation Programs	
[ ] Blood Lead	
[ ] Erythrocyte Protoporphyrin	
[ ] **Urinalysis**	
[ ] **Urine Pregnancy Testing**	
* **Virology**	
[ ] General	
[ ] Limited	
[ ] Direct Detection	

* **COMPLETE APPROPRIATE QUESTIONNAIRE(S) ENCLOSED**

PPI:

10. CERTIFICATION	YES	NO
I HAVE RECEIVED AND READ COPIES OF THE FOLLOWING DOCUMENTS:		
Part 19 of 10 NYCRR - Duties and Qualifications of Clinical Laboratory Directors (3/96)	✓	
Part 34 of 10 NYCRR - Health Care Practitioner Referrals (1/94)	✓	
Part 58 of 10 NYCRR - Clinical Laboratories (2/94) and Blood Banks (1988 Revision under review)	✓	
Part 63 of 10 NYCRR - Aids Testing and the Confidentiality of HIV-Related Information (1/94)	✓	
Part 70 of 10 NYCRR - Regulated Medical Waste (2/93)	✓	
Article 2, Title II-D of the Public Health Law - Health Care Practitioner Referrals (2/96)	✓	
Article 5, Title V of the Public Health Law - Clinical Laboratory and Blood Banking Services	✓	
Article 5, Title VI of the Public Health Law - Laboratory Business Practices (2/96)	✓	
Laboratory Standards issued by the Department	✓	

I understand that under section 577.1(a) of the Public Health Law the permit of this laboratory may be revoked, suspended, limited, or annulled if any fact is misrepresented in this application. Changes to any of the information in this application must be reported to the Clinical Laboratory Evaluation Program immediately by the laboratory director(s) or owner. I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding my initial and continuing eligibility for said laboratory permit. Further, I understand that offering a false instrument constitutes a crime under the penal law of the State of New York.

I understand that by signing this application form I agree to any investigation made by the Department of Health to verify or confirm the information I have given or any other investigation made by them in connection with my request for this laboratory permit. If additional information is requested, I will provide it. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.

In signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a laboratory permit is true and correct.

THE $1,100.00 REGISTRATION AND INSPECTION AND REFERENCE FEE MUST BE INCLUDED WITH THIS APPLICATION. PLEASE ENCLOSE A CHECK MADE PAYABLE TO THE NEW YORK STATE DEPARTMENT OF HEALTH.

Milan Babich, M.D. Print Name of Director	 Signature of Director	4/6/99 Date
DAVID C. FLEISNER Print Name of Owner	 Signature of Owner	4/8/99 Date
Print Name of Assistant Director	Signature of Assistant Director	Date
Print Name of Assistant Director	Signature of Assistant Director	Date
Print Name of Assistant Director	Signature of Assistant Director	Date

LABORATORY PFI & CODE NUMBERS: 1
NAME AND ADDRESS OF LABORATORY: BioSafe Laboratories, Inc.
8600 W Catalpa Ave.
Chicago, IL. 60656

NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, P.O. BOX 509
ALBANY, NEW YORK 12201-0509

ONCOLOGY-SERUM AND SOLUBLE TUMOR MARKERS QUESTIONNAIRE

Complete if the laboratory holds or is applying for a permit in this category. Referring to the enclosed instructions indicate the manufacturer, kit and method (RIA, EIA etc.) used for each type of test performed. Processing of your application and mailing of proficiency testing specimens will be delayed until this questionnaire has been received.

Analyte	Instrument Code	Reagent Code	Numbers of Samples Analyzed in Last 12 Months
☐ AFP	2	3	4
☐ CEA	5	6	7
☒ PSA	8 M P R	9 H Y 4	10
☐ Free PSA	11	12	13
☐ CA125	14	15	16
☐ CA15-3	17	18	19
☐ CA19-9	20	21	22
☐ CA27.29	23	24	25
☐ NMP22	26	27	28
☐ Bard BTA	29	30	31
☐ AuraTek	32	33	34
☐ Other* _____	35	36	37
	38	39	40

Are there any other tests your laboratory is currently performing that are used in the diagnosis or management of cancer (do not include pathology/cytology)? No ✓ Yes _____ If yes, describe.*

The laboratory director and all responsible assistant directors must sign below. For renewal applications, refer to page 2 for the current responsibilities of each assistant director.

4/6/99 — Date
Signature, Laboratory Director — 41 CQ Code

Date
Signature, Assistant Director — 42 CQ Code

Additional responsible assistant director(s) must also sign and print name(s) below or use an additional sheet.

DOH-178A (2/98)

LABORATORY PFI & CODE NUMBER:
NAME AND ADDRESS OF LABORATORY:
BioSafe Laboratories, Inc.
8600 W. Catalpa Ave.
Chicago, IL 60656

NEW YORK STATE DEPARTMENT OF HEALTH
WADSWORTH CENTER
CLINICAL LABORATORY EVALUATION PROGRAM
EMPIRE STATE PLAZA, P.O. BOX 509
ALBANY, NEW YORK 12201-0509

DIAGNOSTIC IMMUNOLOGY - DIAGNOSTIC SERVICES QUESTIONNAIRE

Indicate all analytes that you currently test for or wish to apply for below. Referring to the enclosed instructions, enter under column I the code for the test technique you will be using; under II, enter the code for the test manufacturer; and under III enter the number of tests your laboratory performed in the last calendar year. Please note: If you perform any of the tests indicated below on donors of human organs and/or tissues for transplantation you should apply for the Donor Services category and complete the Donor Services Questionnaire DOH-679(b). **Processing of your application and mailing of proficiency testing specimens will be delayed until this questionnaire has been received.**

ANALYTE	I	II	III
Alpha-1-antitrypsin			
Antinuclear Ab			
Antistreptolysin O			
Borrelia burgdorferi Ab			
B. burgdorferi Western blot			
Complement C3			
Complement C4			
Cryptococcus neoformans Ag			
Cytomegalovirus Ab			
Hepatitis B core Ab			
Hepatitis B surface Ag			
Hepatitis Be Ag			
Hepatitis C Ab			

ANALYTE	I	II	III
Heterophile (inf. mono.)			
HTLV-I-Ab EIA			
HTLV-I-Western Blot			
Immunoglobulin A			
Immunoglobulin E	4	32	0
Immunoglobulin G			
Immunoglobulin M			
Rheumatoid factor			
Rubella Ab			
Rubella IgM Ab			
Syphilis-reagin Ab			
Syphilis-treponemal Ab			

The laboratory director and all responsible assistant directors must sign below. For renewal applications, refer to page 2 for the current responsibilities of each assistant director.

4/6/99
Date

Signature, Laboratory Director

Milan Babich, M.D
Print Name or CQ Code

Date

Signature, Assistant Director

Print Name or CQ Code

Additional responsible assistant director(s) must also sign and print name(s) below or use an additional sheet.

DOH-679a(2/98)

New York State Department of Health
Wadsworth Center
Clinical Laboratory Evaluation Program

FACILITY PERSONNEL

PFI:
LABORATORY:
ADDRESS:
CITY:
STATE:
ZIP CODE:

CONSULTANT:

SURVEY DATE(S):

LABORATORY TESTING HOURS:

LABORATORY DIRECTOR:

LABORATORY ASSISTANT DIRECTOR(S):

PFI:

Survey Date:

Page ____ of ____

Employee Name		Education			Yrs Exp	Job Title	Dept.	Shift			Hrs: FT PT PD	CLEP Review			
Last	First	Degree	Major	Year				1	2	3		Appr. as:	Comments:	Reviewed by	Review date:

OII-709 Revised October 1998

S=Supervisor; MT= Medical Technologist; MLT= Medical Laboratory Technician; CT Cytotechnologist; HT- Histotechnologist

PPR

Survey Date:

Page ____ of ____

CLEP Review

Employee Name		Education			Yrs Exp	Job Title	Dept	Shift	Hrly FT, PT, PD	Appr. asc	Comments	Reviewed by	Review date
Last	First	Degree	Major	Year				1 2 3 W					
Tyrrell	Steven	BS	Biology	1989	10	S	R&D	X	40, FT				
Dalbke	Douglas	BS	MT	1977	18	S	Lab	X	40, FT				
Le Bui	Tuan	BS	MT	1982	6	MT	Lab/Ass	X	40, FT				
Warner	Cheryl	BS	Micro	1972	1	MT	R&D	X	20, PT				
Grasso	Barbara	BS	Biology	1988	1	MT	Lab/Ass	X	40, FT				
Hendrikse	Patricia	BS	MT	1976	22	MT	Lab	X	40, FT				

CLINICAL LABORATORY EVALUATION PROGRAM
WADSWORTH CENTER
NEW YORK STATE DEPARTMENT OF HEALTH
EMPIRE STATE PLAZA, PO BOX 509
ALBANY, NEW YORK 12201-0509

OFFICE USE ONLY
Fee $
Fee No.
Date Rec'd

APPLICATION FOR CERTIFICATE OF QUALIFICATION - CLINICAL LABORATORY DIRECTOR/ASSISTANT DIRECTOR

Please read the enclosed Part 19 10NYCRR for a description of certificate of qualification requirements and read and follow the instructions carefully since submission of incomplete or incorrect applications will delay processing.

NOTE: You must enclose a $40.00 application fee payment. Your check or money order should be made payable to the New York State Department of Health.

1. TYPE OF APPLICATION: ☒ Initial ☐ Renewal ☐ Amendment

2. PERSONAL INFORMATION:

Last Name	First Name	MI	Any other name(s) you have been known by (i.e., maiden name)
Babich	Milan		

Home Address (Street)	City	State	Zip
15004 Pleasant Valley Rd.	Woodstock	IL	60098

Telephone Number (Area Code)	Social Security No.
(Home) 815.338.8955 (Work) 773.693.0400	

3. GRADUATE/PROFESSIONAL EDUCATION: List all medical schools, colleges and universities attended in chronological order whether or not a degree was received. Renewal applicants need only list any education gained since the last application.

Name of Medical School, College or University	Location (City, State)	Major Subject	Month Received	Year Received	Degree
University of Zagreb,					
Medical School Rijeka	Croatia	Medicine		1962	M.D.

List any additional education in the same format on an attached continuation sheet.

4. BOARD CERTIFICATION: Initial applicants must provide a copy of their Board Certificate(s).

American Board of Pathology	5/6/74

List any additional board certifications in the same format on an attached continuation sheet.

5. LICENSURE: Physicians and dentists who are licensed and registered with the New York State Education Department must provide a copy of their current registration. Applicants not licensed in New York State but licensed in another state must provide a copy of their current registration in their state of practice. Unlicensed applicants must provide an official copy of their doctoral transcripts.

Are you licensed and currently registered to practice medicine or dentistry in New York State? ☐ Yes ☒ No

Are you licensed and currently registered to practice medicine or dentistry in any other state? ☒ Yes ☐ No

Physician + Surgeon	36-43989	IL	1971	7/31/99

List any additional licensure information in the same format on an attached continuation sheet.

6. POSTDOCTORAL TRAINING & EXPERIENCE: List all positions held in reverse chronological order. Renewal applicants must list all training or experience gained since the last application whether or not their duties have changed.

Name, Address and Description of Institution (most recent first)	Name of Director or Supervisor	Your Title	From Month/Year	To Month/Year
Evanston Hospital			1971	1973
Describe duties by specialty: Residency Training - Anatomic/Clinical Pathology				
Edgewater Hospital Chicago, IL			1969	1971
Describe duties by specialty: Residency Training - Anatomic/Clinical Pathology				

List any additional experience in the same format on an attached continuation sheet.

7. CURRENT EMPLOYMENT: All sites of current employment must be listed along with job titles, whether as laboratory director or otherwise, and the name of your director or supervisor.

Name, Address and Description of Institution	Name of Director or Supervisor	Your Title	From Month/Year
Sherman Hospital Elgin, IL	S. Kim, M.D.	Pathologist	1989
Description of Duties: Anatomic/Clinical Pathology Microbiology, Chemistry, LIS.			
BioSafe Laboratories, Inc. Chicago, IL.		Laboratory Director	3/1999
Description of Duties:			

List any additional current employment in the same format on an attached continuation sheet.

Applicants are encouraged to include a copy of their current curriculum vitae.

B. CATEGORIES REQUESTED: Be sure to check off each category you seek to hold on your certificate. You will not be considered for any category you do not apply for. Renewal and amendment applicants check only additional categories requested.

CATEGORIES	REQUIREMENTS	
	MD, License, Registration, Recency and	Doctoral Degree, Recency and
☐ Bacteriology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Blood Banking Collection - Comprehensive	Experience	Experience
☐ Blood Banking Collection - Limited	ABP(CP), ABIM(Hem) or Experience	Experience
☐ Blood Lead	ABP(CP), ABCC(TC), ABFT or Experience	ABCC(TC),ABFT or Experience
☐ Blood pH and Gases	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Experience
☐ Cellular Immunology - Limited I ☐ Cellular Immunology - Limited II ☐ Cellular Immunology - Limited IIB ☐ Cellular Immunology - Limited III ☐ Cellular Immunology - Limited IV	Experience	Experience
☒ Clinical Chemistry	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Experience
☐ Cytogenetics	Experience	Experience
☐ Cytopathology	ABP(AP)	
☒ Diagnostic Immunology	ABP(CP), ABMM, ABMLI or Experience	ABMM, ABMLI or Experience
☐ Drug Analysis/Qualitative	ABP(CP), ABCC(CC), ABCC(TC), ABFT or Experience	ABCC(CC), ABCC(TC), ABFT or Experience
☐ Endocrinology	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Experience
Erythrocyte Protoporphyrin	ABP(CP), ABCC(TC), ABFT or Experience	ABCC(TC), ABFT or Experience
☐ Forensic/Identity Testing	Experience	Experience
☐ Forensic Toxicology	ABCC(TC), ABFT or Experience	ABCC(TC), ABFT or Experience
☐ Genetic Testing	Experience	Experience
☐ Hematology	ABP(CP), ABIM(Hem) + 6 months Training, or Experience	Experience
☐ Histocompatibility	Experience	Experience
☐ Histopathology ☐ Oral Pathology ☐ Dermatopathology	ABP(AP) ABP(AP) ABP(AP) or ABP(DP)	 ABOP(DDS only)
☐ Immunohematology	ABP(CP) or Experience	Experience
☐ Mycobacteriology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Mycology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Oncofetal Antigens-Fetal Defect Markers	Experience	Experience
☒ Oncology-Gene and Soluble Tumor Markers ☐ Oncology-Molecular Detection	Experience	Experience
☐ Parasitology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Paternity/Identity Testing -HLA Testing ☐ Paternity/Identity Testing -Blood Genetic Marker Testing ☐ Paternity/Identity Testing -DNA Testing	Experience	Experience
☐ Therapeutic Drug Mon./Quant. Tox.	ABP(CP), ABCC(CC), ABCC(TC) or Experience	ABCC(CC), ABCC(TC) or Experience
☐ Transfusion Services	ABP(BB/TM), ABP(CP) + 6 months Training, ABIM(Hem) + 6 months Training, or Experience	
☐ Virology	ABMM or Experience	ABMM or Experience

8. CATEGORIES REQUESTED: Be sure to check off each category you seek to hold on your certificate. You will not be considered for any category you do not apply for. Renewal and amendment applicants check only additional categories requested.

CATEGORIES	REQUIREMENTS	
	MD, Licensu, Registration, Residency and	Doctoral Degree, Residency and
☐ Bacteriology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Blood Banking Collection - Comprehensive	Experience	Experience
☐ Blood Banking Collection - Limited	ABP(CP), ABIM(Hem) or Experience	Experience
☐ Blood Lead	ABP(CP), ABCC(TC), ABFT or Experience	ABCC(TC),ABFT or Experience
☐ Blood pH and Gases	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Experience
☐ Cellular Immunology - Limited I ☐ Cellular Immunology - Limited II ☐ Cellular Immunology - Limited IIB ☐ Cellular Immunology - Limited III ☐ Cellular Immunology - Limited IV	Experience	Experience
☒ Clinical Chemistry	ABP(CP), ABCC(CC) or Experience	ABCC(CC) or Experience
☐ Cytogenetics	Experience	Experience
☐ Cytopathology	ABP(AP)	
☒ Diagnostic Immunology	ABP(CP), ABMM, ABMLI or Experience	ABMM, ABMLI or Experience
☐ Drug Analysis/Qualitative	ABP(CP), ABCC(CC), ABCC(TC), ABFT or Experience	ABCC(CC), ABCC(TC), ABFT or Experience
☐ Erythrocyte Protoporphyrin	ABP(CP), ABCC(TC), ABFT or Experience	ABCC(TC), ABFT or Experience
☐ Forensic/Identity Testing	Experience	Experience
☐ Forensic Toxicology	ABCC(TC), ABFT or Experience	ABCC(TC), ABFT or Experience
☐ Genetic Testing	Experience	Experience
☐ Hematology	ABP(CP), ABIM(Hem) + 6 months Training, or Experience	Experience
☐ Histocompatibility	Experience	Experience
☐ Histopathology ☐ Oral Pathology ☐ Dermatopathology	ABP(AP) ABP(AP) ABP(AP) or ABP(DP)	ABOP(DD5 only)
☐ Immunohematology	ABP(CP) or Experience	Experience
☐ Mycobacteriology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Mycology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Oncofetal Antigens-Fetal Defect Markers	Experience	Experience
☒ Oncology-Sera and Soluble Tumor Markers ☐ Oncology-Molecular Detection	Experience	Experience
☐ Parasitology	ABP(CP), ABMM or Experience	ABMM or Experience
☐ Paternity/Identity Testing -HLA Testing ☐ Paternity/Identity Testing -Blood Genetic Marker Testing ☐ Paternity/Identity Testing -DNA Testing	Experience	Experience
Ther. Sub. Mon./Quant. Tox.	ABP(CP), ABCC(CC), ABCC(TC) or Experience	ABCC(CC), ABCC(TC) or Experience
☐ Transfusion Services	ABP(BB/TM), ABP(CP) + 6 months Training, ABIM(Hem) + 6 months Training, or Experience	
Virology	ABMM or Experience	ABMM or Experience

6. Post Doctoral Training and Experience (cont.)

Name and Address of Institution	Name of Program	Title	From	To
St. Mary of Nazareth Hospital Ctr. Chicago, IL		Medical Director of Pathology Dept.	1974	1989
Describe duties by specialty. Medical Director				
Describe duties by specialty.				

9. CERTIFICATION

a. Have you ever had charges of administrative violations of local, state or federal laws, rules and regulations, including, but not limited to, the Public Health Law or related statutes, concerning the provision of health care services or reimbursement for such services sustained against you? Are such charges currently pending?

☐ Yes ☒ No

If yes, please provide details on a separate sheet and attach to this form.

Have you ever been convicted of any crime, including, but not limited to, any offense related to the furnishing of or billing for clinical laboratory services and medical care, services or supplies, which is considered an offense involving theft or fraud? Are such charges currently pending?

☐ Yes ☒ No

If yes, please provide details on a separate sheet and attach to this form.

b. I understand that under Section 577.1(a) of the Public Health Law my Certificate of Qualification may be revoked, suspended, limited or annulled if any fact is misrepresented in this application. Changes in any of the information in this application must be reported to the Clinical Laboratory Evaluation Program immediately. I also understand that additional penalties may apply if I misrepresent, conceal, or fail to disclose facts or information regarding my initial or continuing eligibility for a Certificate of Qualification, including conviction of any crime related to billing for laboratory services, omission or misrepresentation of material facts in applying for professional license, permit or registration related to the operation of a clinical laboratory or the concealment of ownership or controlling interest in a clinical laboratory. Further, I understand that offering a false instrument constitutes a crime under the Penal Law of the State of New York.

I understand that by signing this application form I agree to any investigations made by the Department of Health to verify or confirm the information I have given or any other investigation made by them in connection with my request for this Certificate of Qualification. If additional information is requested, I will provide it. Further, I understand that, should this application or my status be investigated at any time, I agree to cooperate in such an investigation.

In signing this application, I hereby certify that the information I have given the Department of Health as a basis for obtaining a Certificate of Qualification is true and correct.

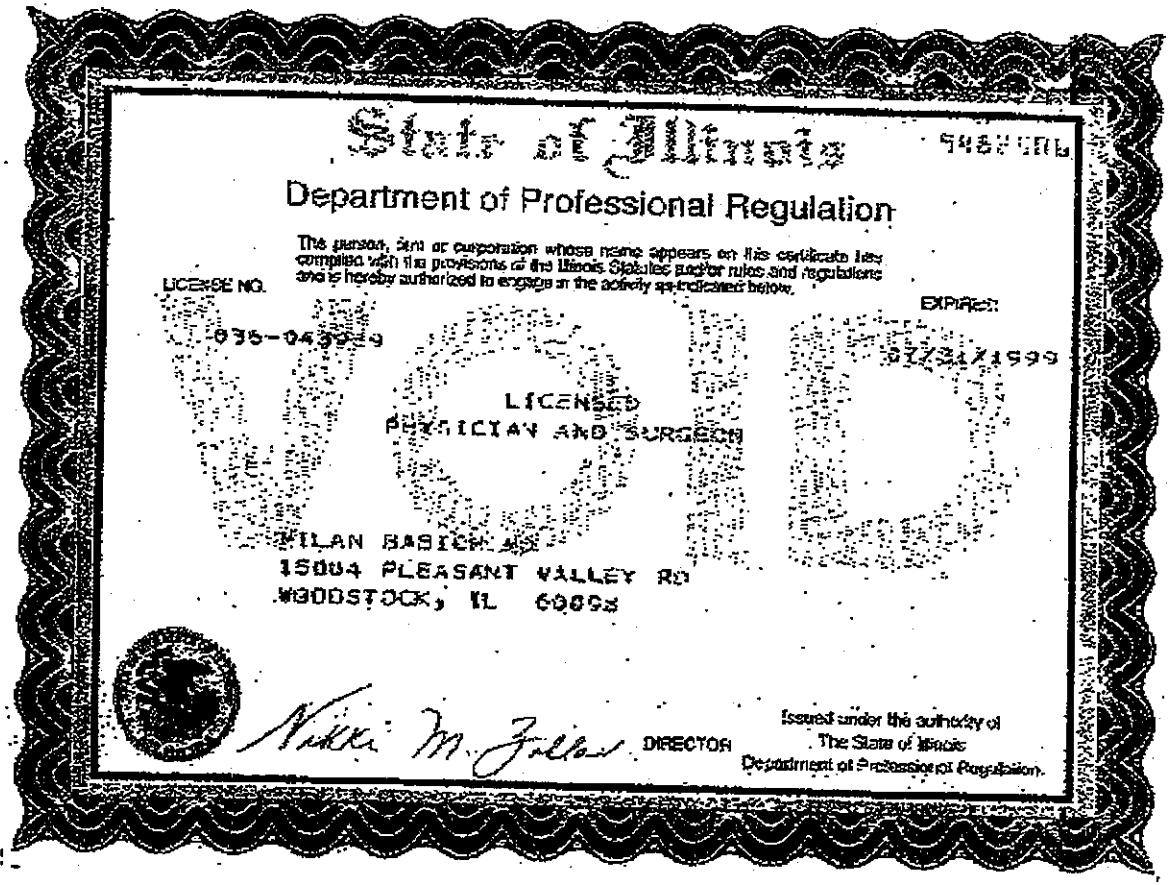
Signature

4/7/99
Date

The $ 40.00 application fee must be included with this application.

Submit forms to:

CLINICAL LABORATORY EVALUATION PROGRAM
WADSWORTH CENTER
NEW YORK STATE DEPARTMENT OF HEALTH
EMPIRE STATE PLAZA, PO BOX 509
ALBANY, NEW YORK 12201-0509



State of Illinois

Department of Professional Regulation

The person, firm or corporation whose name appears on this certificate has complied with the provisions of the Illinois Statutes and/or rules and regulations and is hereby authorized to engage in the activity specified below.

LICENSE NO.

035-0

EXPIRES:

LICENSED
PHYSICIAN AND SURGEON

MILAN BASICH, MD
15004 PLEASANT VALLEY RD
WOODSTOCK, IL 60098

Nikki M. Zollar DIRECTOR

Issued under the authority of
The State of Illinois
Department of Professional Regulation

The American Board of Pathology

Herewith certifies that

Milan Babich, M.D.

Has pursued an accepted course of graduate study and clinical work and has demonstrated his proficiency to the satisfaction of the Board of Trustees

Therefore on this twenty-sixth day of May, 1974

The American Board of Pathology

has granted this certificate of qualification for the practice of

Anatomic and Clinical Pathology

President	Vice-President	Secretary	Treasurer

[redacted]

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